CHAPTER

4

Systemic and Strategic Therapies

Learning Objectives

After reading this chapter and a few hours of focused studying, you should be able to:

- **Theory:** Describe the following elements of systemic–strategic family therapy:
  - Process of therapy
  - Therapeutic relationship
  - Case conceptualization
  - Goal setting
  - Interventions
- **Case Conceptualization and Treatment Plan:** Complete theory-specific case conceptualizations and treatment plans for systemic–strategic using templates that are provided.
- **Research:** Provide an overview of significant research findings for systemic–strategic therapies and describe key elements of the following evidence-based treatment: multisystemic and brief strategic family therapy.
- **Diversity:** Analyze strengths, limitations, and appropriate applications for using systemic–strategic approaches with clients in relation to their social location/diverse identities, including but not limited to ethnic, racial, and/or sexual/gender identity diversity.
- **Cross-Theoretical Comparison:** Compare how systemic–strategic therapies utilize interpersonal patterns (IPs) with other approaches described in this book.

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Through time, you learn how to look at a system and appreciate it for what it is. Never expect the system to be different. It's important for the therapist and for the trainee to train themselves to see the system, to be interested in it, to appreciate this kind of a system without wanting to change it.
—Boscolo, Cecchin, Hoffman, & Penn, 1987, p. 152)

Lay of the Land

Chapter 3 outlined the systemic foundations of various kinds of therapy, especially the contributions of the Bateson group. This chapter discusses these therapies in more detail. Three teams of therapists developed what are broadly considered to be systemic or strategic theories:

- **Mental Research Institute (MRI; a.k.a. the Palo Alto group):** After the Bateson team concluded their groundbreaking research on family dynamics with schizophrenia, Richard Fisch and Don Jackson worked together to found the Mental Research Institute, which has since served as the most influential training center in family therapy, inspiring Jay Haley's strategic work (which he conceptualized prior to the MRI approach), the Milan team's systemic approach, Virginia Satir's human growth model (see Chapter 6), and solution-focused brief therapy (see Chapter 9). The Brief Therapy Project at the MRI was designed to find the quickest possible resolution to client complaints, typically relying on action-based interventions (Watzlawick & Weakland, 1977; Watzlawick, Weakland, & Fisch, 1974; Weakland & Ray, 1995).
- **Milan Systemic Therapy:** After joining together to further Selvini Palazzoli's work with families who have anorectic or schizophrenic children, Mara Selvini Palazzoli, Gianfranco Cecchin, Giuliana Prata, and Luigi Boscolo formed the Milan team. Early in their work, they studied at the MRI and returned to Italy to design a therapeutic model that embodied the cybernetic systems theory of Bateson (1972, 1979; see Chapter 3). This model is called "Milan systemic therapy," or "long-term brief therapy." Milan therapists closely attend to how client language shapes family dynamics (Selvini Palazzoli, Cecchin, Prata, & Boscolo, 1978).
- **Strategic Therapy:** One of the original associates at the MRI, Jay Haley developed his own form of systemic therapy with his then-wife, Cloe Madanes. Their approach focuses on the use of power and, in their later work, love in family systems (Haley, 1976).
- **Tomm's IPscope:** Introduced in Chapter 3, Karl Tomm and colleagues (2014) have developed a contemporary systems approach that tracks not only systemic processes related to the presenting problem but also to healing, wellness, and change. The conceptualization piece of this approach is clearly systemic but many of the interventions have strong postmodern influences.

Systemic–Strategic Family Therapy

In a Nutshell: The Least You Need to Know

Using what most therapists consider the classic family therapy method, systemic family therapists conceptualize the symptoms of individuals within the larger network of their family and social systems while maintaining a nonblaming, nonpathologizing stance toward all members of the family. Systemic therapies are based on **general systems theory** and **cybernetic systems theory**, which propose that families are living systems characterized by certain principles, including **homeostasis**, the tendency to maintain a particular range of behaviors and norms, and **self-correction**, the ability to identify when the system

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has gone too far from its homeostatic norm and then to self-correct to maintain balance (see Chapter 3). Systemic therapists rarely attempt linear, logical solutions to "educate" a family on better ways to communicate—this is almost never successful. Instead, they tap into the systemic dynamics to effect change. They introduce small, innocuous, yet highly meaningful alterations to the family's interactions, allowing the family to naturally reorganize in response to the new information. Because this method effects change quickly, systemic therapies were the original *brief therapies*. Karl Tomm's (Tomm, St. George, Wulff, & Strong, 2014) contemporary systemic approach, the IPscope model, also incorporates sociocultural interpersonal patterns and more postmodern interventions.

The Juice: Significant Contributions to the Field

If you remember anything from this chapter, it should be the ideas discussed below.

Systemic Reframing: Juice from MRI

Reframing is a central technique that is found in most forms of systemic family therapy, such as structural therapy (see Chapter 5) and experiential family therapy (see Chapter 6). The MRI team approached reframing from a constructivist position that is summarized in the following propositions (Watzlawick et al., 1974):

1. We experience the world through our categorizations of objects, people, and events ("If my husband does not bring flowers or offer other romantic gestures, he does not really love me").
2. Once an object, person, or event is categorized, it is very difficult to see it as part of another category ("Our relationship must be in trouble if he has stopped being romantic").
3. Reframing uses the same "fact" that supports one categorization to support another categorization; once a person sees things using this second perspective, it is difficult to see the original situation in the same way (e.g., "My husband's drop in romance may mean that he has become more comfortable and authentic in the relationship rather than playing courting games; it could be a sign of deepening commitment").

The basic component of reframing is finding an alternative yet equally plausible explanation (categorization) for the same set of facts. Of course, the key is identifying the client's current worldview and finding an equally viable frame for the problem behavior from the client's perspective. Reframing in systemic family therapies typically involves considering the role of the symptom in the broader relational system, often highlighting how it helps maintain balance (homeostasis) in the relationship. Unlike in cognitive–behavioral therapies, clients are not expected to literally believe or adopt the proposed reframe; instead, it is hoped that the reframe will be "news that makes a difference," allowing clients to generate useful understandings. For example, with certain couples it makes sense to reframe their arguments as a way to build passion and maintain connection in their relationship. Such a reframe is offered to a couple without expectation that it will have a specific effect, because the system is considered a unique entity that will make its own meaning. If the couple does not find the reframe helpful, perhaps not responding or disagreeing with it, the therapist uses this information to better understand their worldview and then identify other potentials for reframing the problem.

Circular Questions: Juice from Milan

Regardless of which therapeutic model one chooses to practice, **circular questions** are perhaps one of the most useful techniques when working with more than one person in the room. Such questions help: (a) assess and (b) make overt the overall dynamics and interactive patterns in the system, thereby reframing the problem for all participants without the therapist having to verbally provide a reframe, as already described in Systemic

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Reframing (Selvini Palazzoli et al., 1978; Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). For example, I once had a family come to me complaining about a child's "anger problem." After they described the child's "problem" behavior, I inquired about how the rest of the family responded to the child's anger. The mother reported that she responded by getting frustrated and often yelled, and the father sharply corrected the child. As they listened to themselves describe their responses, both conceded that they responded to his anger with anger; they also noted that the younger sister disappeared into another room or somehow disengaged because of the intensity. As the parents began to look at their half of the interaction pattern, it became clear that anger was highly "contagious" for the three of them, while it evoked anxiety in the daughter. These questions allowed the family to view their "son's anger problem" in the context of the broader interaction pattern, thus opening new options for relating.

Specific forms of circular questions (Cecchin, 1987) include the following:

- **Behavioral sequence questions:** Therapists use these questions to trace the entire sequence of behaviors that constitute the problem: "After John got mad, what did mom do? What did dad do? What did his sister do?" And after the response, "What did John do next?" The therapist follows the sequence of interactions until homeostasis is restored.
- **Behavioral difference questions:** Therapists use behavioral difference questions when clients start labeling people and assuming that a particular behavior is part of a person's inherent personality. For example, if a child claims, "My mom's a nag," the therapist would ask, "What does she do that makes her a nag?" The description of problem behavior, "tells me to do things," is then compared with others: "How does your dad ask you to do things? Your teacher? How do *you* ask others to do things?"
- **Comparison and ranking questions:** Comparison and ranking questions are useful for reducing labeling and other rigid descriptions in the family: "Who is the most upset when Jackie has an episode? Who is the least affected? Who is the most helpful during these times? The least helpful?"
- **Before-and-after questions:** When a specific event has occurred, before-and-after questions can be useful in assessing how the event affected the family dynamics: "Did you and your mother fight more or less after your dad got sick?"
- **Hypothetical circular questions:** Hypothetical questions are used to offer a scenario and have family members describe how each is likely to respond: "If mom were suddenly placed in the hospital, who would be most likely to be at her bedside? The least likely?"

Try It Yourself

Find a partner and take turns asking circular questions related to a current life problem. In what ways do these questions change how you view or define the problem?

Directives: Juice from Strategic Therapy

Directives are the most basic of strategic techniques (Madanes, 1991); however, they are also the most frequently misunderstood by new therapists. In essence, directives are directions for the family to complete a specific task, usually between sessions but sometimes within the session. The tasks are rarely "logical" or linear solutions to the problem; instead they somehow "perturb" the system's interaction patterns to create new interactions (Haley, 1987). Thus, if a couple is arguing, the therapist will *not* ask them to set the timer

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so that each person speaks for 5 minutes followed by the other summarizing or responding for the next 5 minutes. That would be a logical or linear directive such as those found in cognitive–behavioral family therapy (see Chapter 8). Nor will the therapist ask the couple to simply stop or learn a communication technique; the assumption is that if they could do this, they would have already done so. Instead, the therapist asks them to argue but to change one or two key elements, such as the place, timing, or turn-taking style. A directive may be to have their "normal" argument while fully clothed in the bathtub or to have it after rearranging furniture to simulate a courtroom.

Directives get people out of their ruts with the *smallest change possible*. When these directives work, clients generally experience a simultaneous shift in emotions, insight, and behavior. I like to compare it to a chocolate–vanilla swirl soft serve ice cream: the changes are perfectly synchronized and come fully integrated together. From the clients' perspective, directives jolt them out of their usual life patterns, and generally the clients know exactly how to shift themselves to make the necessary changes. Unlike insight in traditional psychodynamic therapy, directives create visceral aha moments because clients are in the midst of the action that needs to change. It is a bit like sudden enlightenment in the Zen tradition—hence, I like to think of systemic therapists as the Zen Masters and Mistresses of the field.

IPscope: Juice from Calgary

See Chapter 3 for a complete description.

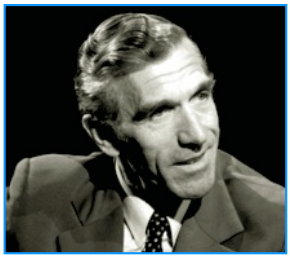
Rumor Has It: The People and Their Stories

Portrait of Don D. Jackson. Copyright MRI Mental Research Institute. www.mri.org

The Clinical MRI Team

Don Jackson

A brilliant clinician and founder of the MRI in 1958, Jackson was a principal figure in family therapy, especially in the development of concepts such as family homeostasis, family rules, relational quid pro quo, conjoint therapy, interactional theory, and, along with others at MRI, the double-bind theory (MRI, 2002; Watzlawick, Bavelas, & Jackson, 1967); he also was one of the first to question the myth of normality (Jackson, 1967).



Portrait of Paul Watzlawick. Copyright MRI Mental Research Institute. www.mri.org

Paul Watzlawick

Born in Austria, Paul Watzlawick was a communications theorist who cofounded the Brief Therapy Center at the MRI with Weakland and Fisch, with a goal of developing an ultrabrief approach to therapy (Watzlawick, 1977, 1978/1993, 1984, 1990). In his later writings, Watzlawick explored implications of radical constructivism for therapy and human communication in cleverly titled books such as *How Real Is Real?* (1977), *The Invented Reality* (1984), *Ultra Solutions: How to Fail Most Successfully* (1988), and *The Situation Is Hopeless but Not Serious: The Pursuit of Unhappiness* (1993).

Portrait of John Weakland. Copyright MRI Mental Research Institute. www.mri.org

John Weakland

Originally trained as a chemical engineer, Weakland joined the Bateson group and helped to articulate the application of communication theory, emphasizing the importance of basing theory on concrete and observable behaviors rather than inferences or constructs, which are not observable (MRI, 2002). Along with Haley, Weakland integrated Erickson's work at the MRI with the Brief Therapy Project.

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Portrait of Richard Fisch. Copyright MRI Mental Research Institute. www.mri.org

Richard Fisch

After initially proposing the creation of the MRI, Richard Fisch was appointed by Jackson to be the director of the new Brief Therapy Project, which was inspired by Erickson's brief hypnotic work; the goal was to develop a highly teachable form of brief psychotherapy (Watzlawick et al., 1974). Thus, Fisch spearheaded the development of the therapy model for which the MRI is most famous, studying how to influence others with words and indirect influence (Fisch & Schlanger, 1999; Fisch, Weakland, & Segal, 1982; MRI, 2002).

Wendel Ray

Former director and senior research fellow at the MRI, Wendel Ray has been instrumental in ushering systemic therapies into the 21st century, working with Bradford Keeney (see Chapter 3) to develop *resource-focused therapy,* a strength-based systems therapy (Ray & Keeney, 1994); with Milan team colleagues to further develop systemic concepts, such as *irreverence, cybernetics of prejudices,* and *eccentricity* (Cecchin, Lane, & Ray, 1992); and with colleagues at the MRI on theoretical and archival work (Weakland & Ray, 1995). He also serves as the Hammond Endowed Professor of Education and Professor of Family Systems Theory at the University of Louisiana at Monroe.

Barbara Anger-Diaz and Karin Schlanger

Barbara Anger-Díaz and Karin Schlanger train therapists in brief therapy with Latino families; training and therapy are conducted in Spanish at the Latino Brief Therapy and Training Center at the MRI.

Giorgio Nardone

Working closely with Watzlawick in his later works (Nardone & Watzlawick, 1993), Giorgio Nardone founded the Centro di Terapia Strategica in Arezzo, Italy, and the Brief Strategic and Systemic World Network. Founded in 2003, the latter brings together strategic and systemic therapy practitioners from around the world.

The Milan Team

The Milan team included Mara Selvini Palazzoli, Gianfranco Cecchin, Luigi Boscolo, and Giuliana Prata and was founded in 1967 by Selvini Palazzoli, who was studying anorexia in Italy at the time (Campbell, Draper, & Crutchley, 1991). They met weekly without pay, seeing families and studying the work of Bateson and the MRI group and frequently inviting Watzlawick for consultations. The team developed a unique approach that focused on meaning and ritual. In 1979, the team separated along interest and gender lines: Selvini Palazzoli and Prata, primarily researchers, wanted to continue their investigation into treating families with psychotic members, while Cecchin and Boscolo worked together on clinical and training applications. The later work of Selvini Palazzoli and Prata centered on the *invariant prescription* (discussed later in this chapter), while Cecchin and Boscolo explored Keeney's *second-order cybernetics* (1983) and related works, attending to language and the construction of meaning through multiple descriptors and eventually moving toward a more postmodern, social constructionist stance (see Chapter 10). Lynn Hoffman and Peggy Penn, featured in Chapter 10 worked closely with Boscolo and Cecchin.

Strategic Therapists

Jay Haley and Cloe Madanes

Jay Haley, one of the original members of the Bateson team, student of Milton Erickson, and cofounder of the Brief Therapy Project at MRI, developed his own systemic

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Portrait of Jay Hayley. Copyright MRI Mental Research Institute. www.mri.org

approach, strategic therapy (Haley, 1963, 1973, 1976, 1980, 1981, 1984, 1987, 1996; Haley & Richeport-Haley, 2007; MRI, 2002). He and his wife, Cloe Madanes (1981, 1990, 1991, 1993), founded the Family Therapy Institute in Washington, D.C. Their approach is based on the concepts of hierarchy, power, and love, and uses *directives* for interventions.

Eileen Bobrow

Eileen Bobrow founded and directs the Strategic Family Therapy and Training Center at the MRI, which prior to her arrival focused primarily on the Brief Therapy Model developed at the MRI.

Jim Keim

A research fellow at the MRI, Jim Keim (1998) uses strategic therapy to work with families with children diagnosed with oppositional defiant disorder and conduct disorder.

Tomm's IPscope

Karl Tomm

A psychiatrist by training and pioneer of family therapy, Karl Tomm founded the Calgary Family Therapy Centre at the University of Calgary in 1973. For nearly four decades, he has developed and refined his approach for working with families, which draws from both second-order cybernetic concepts as well as contemporary postmodern applications (in fact, he could also be part of Chapter 10 for his postmodern work). Early in his career, he was influenced by Nathan Epstein and the Milan team and later by narrative therapists Michael White and David Epston (see Chapter 10; Collins & Tomm, 2009; Tomm, 1984). Unlike other many systemic–strategic therapists at the time, Tomm (1987a, 1987b, 1988) was most interested in interview questions that facilitated client self-healing rather than interventions in which the therapist strategically attempted to "correct" the system, a view consistent with second-order cybernetics. He also developed *internalized other interviewing,* in which a therapist interviews a client's internalized image of his or her partner (Tomm, 1999). More recently, he has incorporated narrative therapy concepts and has begun conducting research on his approach.

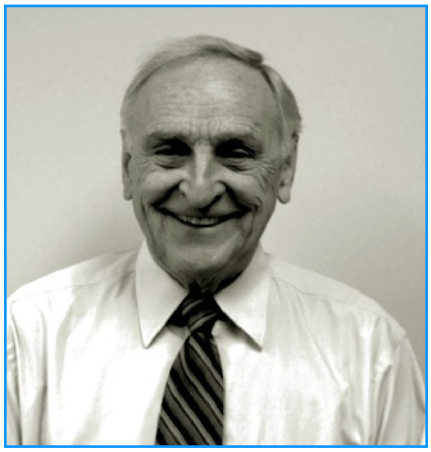

Photo courtesy of Dr. Karl Tomm, www.familytherapy.org

Sally St. George

A professor of family therapy, Sally St. George works with Karl Tomm at the University of Calgary. She and Dan Wulff have been instrumental in developing practices for working with sociocultural interpersonal patterns (SCIPs) and conducting research on the IPscope.

Dan Wulff

A professor of social work and a colleague of Tomm at the University of Calgary, Dan Wulff has worked with St. George to develop practices for working with SCIPs as well as conducting research on the IPscope.

Tom Strong

A professor of counseling psychology and also a colleague of Tomm, Tom Strong (I imagine that gets a bit confusing) focuses his research on the counseling change process as well as social constructionist theories.

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The Big Picture: Overview of Treatment

Systemic and strategic therapies focus solely on resolving the presenting problem, with the therapist imposing no other goals or agendas. Therapists see the presenting problem not as an individual problem but as a relational one, specifically an *interactional* one (Cecchin, 1987; Haley, 1987). Neither an individual nor a relationship is considered "dysfunctional"; instead, the problem is viewed as part of the interactional sequence of behaviors that have emerged through repeated exchanges, with no one person to blame.

The early stages of all three approaches involve getting a clear, behavioral description of the interaction sequence surrounding the problem, beginning with the initial exchange prior to the escalation of symptoms and ending with the interaction sequence that returns the system to homeostasis. Once the therapist has identified the interactional behavioral patterns and meanings associated with the problem, he or she uses one of many potential interventions to interrupt, not correct, this sequence. Much the way a school of fish cannot be shepherded but only interrupted and allowed to regroup, systemic and strategic therapists do not try to linearly instruct clients in preferred behaviors, because it rarely if ever works (Haley, 1987). Instead, they interrupt the problem sequence of behaviors, allowing the family to reconfigure itself around the new information that has been introduced to the system. For example, if a parent and child complain of frequent arguments, the therapist does not try to educate them in better communication. Instead, the therapist interrupts the sequence by reframing the child's defiance as a veiled attempt to remain close to the parent because the child fears the transition to college, or the therapist may ask parent and child to ritualize the process with hats symbolizing their positions. For example, in the case study at the end of this chapter, the therapist working with Alba, a 16-year-old who started drinking and smoking pot after her parents separated, reframes her acting-out behaviors as attempts to bring the parents together over a common goal and to distract the family from the pain of the father's affair; the therapist does not believe Alba does this consciously or intentionally but rather is following the "pull" of the system to restore family homeostasis.

Usually the therapist gives the family a task or reframe before they leave the session, with instructions to either complete the task or reflect on the new interpretation presented by the therapist. The next week, the therapist follows up on the prior week and then designs another task or reframe based on the response to the prior week's intervention. This process continues only as long as is necessary to resolve the presenting problem; then therapy is terminated. To recap, the general flow of systemic or strategic therapies is as follows:

The Process of Systemic Therapy

- **Assess the interactional sequence and associated meanings:** The therapist identifies the interactional behavior sequences that constitute the problem, including the actions and reactions of everyone in the system and the associated meanings.
- **Intervene by interrupting the interactional sequence:** Using a reframing technique or a task, the therapist interrupts the sequence (avoids trying to fix or repair the sequence), allowing the family to reorganize itself in response to the perturbation. *Note: The differences between MRI, strategic, and Milan therapies are primarily seen in the preferred method of interrupting the interactional sequence.*
- **Evaluate outcome and client response:** After the intervention, the therapist assesses the family's response and uses this information to design the next intervention.

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- **Interrupt the new pattern:** The therapist then interrupts the new pattern with another intervention. This continues—interrupt behavioral sequence, allow family to reorganize and respond, and intervene again—until the problem is resolved.

Making a Connection: The Therapeutic Relationship

Respecting and Trusting the System

Systemic therapists respect the family as a system, as an entity that has its unique epistemology, or way of knowing and understanding the world. They have a deep, abiding trust that the system can reorganize itself without the therapist forcing change. Instead, the therapist provides opportunities for the family to reorganize itself. The symptoms are never seen as indicators of individual pathology but rather as the by-product of family interactional sequences that have served a purpose.

Adapting to Client Language and Viewpoint

In the first meeting, the therapist tries to establish a positive, trusting relationship with the client (Nardone & Watzlawick, 1993; Watzlawick, Weakland, & Fisch, 1974). One approach is to adapt to the clients' language, communication style, and worldview, speaking logically with clients who focus on reason and more intensely with clients who have a more emotional manner of expression. First and foremost, the therapist respectfully engages with the client's representational framework or epistemology, including beliefs, values, and language. This is the inverse of traditional psychoanalysis, in which the patient must adapt to the language and viewpoint of the therapist.

Neutrality

In 1978 (Selvini Palazzoli et al.; Selvini Palazzoli et al., 1980), the Milan team first described their therapeutic stance as one of **neutrality**, which has been one of the most misunderstood concepts related to their work (Boscolo et al., 1987). For the Milan team, neutrality connoted not only nonpartiality toward particular family members or problem descriptions but also multipartiality, the willingness to honor all perspectives.

In one sense, neutrality refers to the *pragmatic effect* the therapist has on the family, not the therapist's own feelings (Cecchin, 1987). Thus if, at the end of the session, the family cannot identify which "side" the therapist took, then the therapist has had the effect of being neutral. However, during the session, the therapist often appears to take a side by asking questions that align with a certain person's view of the problem; the therapist must counterbalance this by asking questions that align with each of the other perspectives so that at the end the therapist is viewed as neutral.

Neutrality also implies not becoming attached to particular meanings, descriptions, or outcomes (Boscolo et al., 1987). The Milan team carefully avoided buying into any one description of the problem, *including their own*. Neutrality extended to their own hypotheses and ideas about the family, and they avoided "falling in love" with their own ideas. Later, Cecchin et al. (1992) characterized this form of neutrality as a form of *irreverence* (discussed in next section) that allows for broad maneuverability. When therapists do not rigidly adhere to a particular problem description, they can see more possibilities for intervention rather than focusing on the single solution that fits with their preferred hypothesis.

Irreverence

The concept of irreverence was not highlighted until later in the literature (Cecchin et al., 1992), but—when properly understood—it clearly captures the therapist's relationship to

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the *problem* (not the client). The magic of this approach is derived from the therapist's irreverent relationship with problems.

What is there to be irreverent about? Systemic therapists are irreverent regarding the "catastrophic" appearance of problems. They do not give in to the appearance that a person has a "personality flaw," "illness," "unresolved childhood issue," or other deep, troubling problem, even though problems appear that way, especially to those who live with them. But the systemic therapist knows that appearances are deceiving because problems are intimately connected with the relational and broader social context. In a different context, a person's problem behaviors would be different. The context and problem are always influencing each other. The art of irreverence is to not honor the problem as a mighty foe and assume it has more power than it does. Its power is entirely dependent on its context. With experience, the therapist is able to see through the appearance of a "big, horrible" problem and instead see that the person, problem, and context form a fluid dance—and experience teaches that by changing only a few steps in the dance, the problem shifts, diminishes, and eventually disappears.

Irreverence is felt in the therapist's confidence and unpanicked response to problem issues. It is driven not by disrespect but rather by *fearlessness*. Whatever problem the client brings—whether the loss of a child or a teen's drama of the week—the therapist remains fearless, maintaining a deep sense of calm and faith in systemic processes, knowing that the problems are never as insurmountable as they appear and that systems are inherently self-correcting. Irreverence does not imply lack of empathy or sensitivity. Rather, it allows the therapist to maintain an openness, creativity, and flexibility to provide maximum benefit to the client. In this chapter's case study, the therapist's irreverence toward 16-year-old Alba's decision to start drinking and smoking pot after her parents separated keeps the therapist from being overly panicked about the acting-out behaviors and enables her and the whole family to focus on the issue: Alba's sense of betrayal and loss. By not overreacting to the drinking and drugs—but not ignoring them either—the therapist gives them less power and creates space for more critical issues.

Maneuverability

Maneuverability refers to the therapist's freedom to use personal judgment in defining the therapeutic relationship (Nardone & Watzlawick, 1993; Segal, 1991; Watzlawick et al., 1974). Therapists may choose to maintain an expert position or a one-down stance (see next section), depending on what would be most helpful to the family. Similarly, the therapist may be more distant or more emotionally engaged, depending on the circumstances. Furthermore, the therapist may choose to be disliked by the client or be the "bad guy" in order to achieve the desired change in the family system, always attuned to whatever role might be most beneficial for the family.

The One-Down Stance, or Helplessness

The one-down stance is used to increase clients' motivation, often paradoxically by claiming, "I'm not sure if I am able to handle such a problem" (Segal, 1991). This move is often helpful with clients who act as if their situation is hopeless; when the therapist takes the hopeless stance, the client is motivated to find hope. Systemically this works because in most systems there is a counterbalance: if one person is hopeless, the other feels compelled to be hopeful to maintain a balance. This same dynamic is also observed between couples in crisis: generally one person will manage the crisis, allowing the other one to more fully feel the panic and trauma.

Beyond serving this paradoxical purpose, the one-down stance also expresses a certain attitude toward the family system. Systemic therapists view the system as an entity with its own rules and integrity that must be respected, much like a mountain climber must respect the awesome forces of nature or the sailor an ocean. Like a family system, nature

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and the ocean are not things the therapist can control; instead, there is a deep respect for their power and ways. Thus, the one-down stance is a sincere and genuine position for a systemically trained therapist.

Social Courtesy

Haley (1987) describes the initial stage of therapy as the social stage, a time during which the therapist engages in casual social conversation, about the weather or traffic, to make clients comfortable and reduce their sense of shame: "the model for this stage is the courtesy behavior one would use with guests in the home" (p. 15). Before discussing the problem, the therapist ensures that all members have been properly greeted. During this first social stage, the therapist is assessing interactions and mood (Haley & Richeport-Haley, 2007).

Collaboration

Influenced by second-order cybernetics and social constructionist theories, contemporary systems therapists adopt a more collaborative relationship with clients (Tomm et al., 2014). Rather than assume a strategic posture by trying to directly effect change, contemporary systemic therapists use reflexive questions designed to facilitate client self-healing. in which the therapist and client co-create new meanings and action (Gaete, Sametband, & Sutherland, 2014; Tomm, 1987a).

The Viewing: Case Conceptualization and Assessment

Interactional Patterns

When systemic or strategic therapists view a family, they focus on the **interactional patterns** between people (Boscolo et al., 1987; Watzlawick et al., 1974). To illustrate this focus to new therapists, I have a "family of four" grab hold of a bright yellow rope to form a circle. Then I have them "dance" and move about in various patterns. Initially, the audience's eyes naturally focus on the movement of the dancers, our default, socialized habit of viewing interactions. I then have the family do the dance again, asking the audience to focus exclusively on the yellow rope and how it moves as it traces the interactional patterns of distance and closeness. This is a very gross and incomplete metaphor for how a systemic therapist looks at a family, but I think it helps get the point across: the focus is always on the yellow rope—the interaction—or what Milan therapists call the "game" (Boscolo et al., 1987). Often, English speakers think that the Milan term *family game* implies manipulation and ill intent, meanings the term may have in English. However, that is not the connotation of *game* in the systemic context, which focuses on the relational rules for how the family interacts, rules that are not consciously created but rather naturally emerge from the family interaction pattern.

Family interactions can be hard to detect, especially early in training. The trick is tracing the homeostatic dance (how A responds to B and B in turn responds to A), which involves identifying the earliest triggers or signs of the problem and tracing the increase in tension until the problem or symptom occurs; then continuing to track the interactions until things go back to homeostasis again (everyone seems to forget this last step, which often provides the most useful information for intervention). When observing a family interacting, therapists can assess the dance patterns by focusing less on the content of the conversation and more on the metacommunication (see Chapter 3) and interactions (movement of the rope). Whether action-based or language-based, virtually all interventions used by traditional systemic–strategic therapists have a single intention: interrupt

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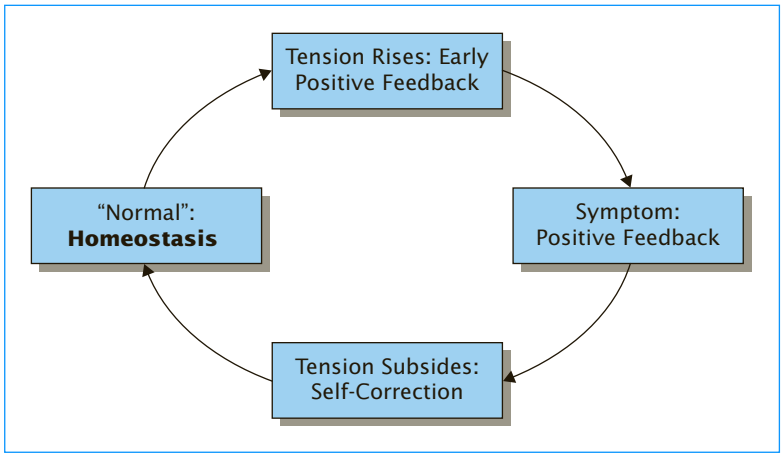
the negative interaction patterns that include the presenting problem or symptom. These interaction patterns can be roughly illustrated as shown here:



For example, if a couple is arguing about how to discipline a defiant child, the therapist will not focus on solving the problem with the child but rather on how the parents communicate: Does each share opinions, thoughts, and feelings? How does each respond to the other's divergent opinion? What strategies does each use to convince the other? Does one person get the last word? How do they get back to "normal"? By focusing on the interactional pattern or couple game for negotiating this type of problem, the therapist can identify where they are stuck.

Identifying the Interactional Sequence

1. **Homeostasis (normality):** Can you describe what things are like when things feel "normal" and "okay"? What are things like before the tension starts?
2. **Start of tension:** Can you tell me how things usually begin? Who does what, and how do others respond? How does the first respond back?
3. **Escalation and symptom:** Can you describe the escalation that leads to [specify the client's specific symptom]? Who does what, and how does each person in the household respond?
4. **Return to homeostasis:** Describe how things get back to normal.

Try It Yourself

Find a partner and use the above questions to assess the interactional sequence for a relational problem.

In addition to observing actual interactions, it is often necessary to ask circular questions to assess the interactional sequence; these questions can be used with individuals, couples, or families. For example, with the couple having trouble with the defiant child, the therapist would ask: "What is happening just before the problem incident? What is each person saying and doing? How does the child respond? How does each parent and anyone else involved respond to the defiance? How does the child respond to this? How do the parents respond to the child next?" and so on, until family homeostasis is restored.

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Questions for Assessing Family Interactions

To develop a concrete description of the interactional pattern, Nardone and Watzlawick (1993, p. 30) recommend that therapists answer the following questions:

- What are the patient's usual, observable behavior patterns?
- How does the patient define the problem?
- How does the problem manifest itself?
- In whose company does the problem appear, worsen, disguise itself, or not appear?
- Where does it usually appear?
- In what situations?
- How often does the problem appear, and how serious is it?
- What has been done and is currently being done (by the patient alone or by others) to resolve the problem?
- Whom or what does the problem benefit?
- Who could be hurt by the disappearance of the problem?

IPscope

Introduced in Chapter 3, contemporary systemic therapists conceptualize use the **IPscope** to identify several interpersonal interaction patterns, which include not only those associated with the problem pathologizing interpersonal patterns (PIPs) but also wellness (WIPs), healing (HIPs), sociocultural (SCIPs), transformative (TIPs), and deteriorating (DIPs) interpersonal patterns. By tracking these multiple interaction patterns, therapists can conceptualize not only the problem but also the most likely interactions that will address the problems, which can serve to guide the therapy process. See Chapter 3 for detailed discussion.

"More of the Same" Solutions

When tracking interactional patterns, MRI therapists also focus on identifying "**more of the same" solutions**—that is, solutions that perpetuate the problem (Watzlawick et al., 1974). For example, if the parents always respond to a child's defiance with some form of lecture and verbal punishment, this would be a "more of the same" solution that is not working for the family. This "attempted solution" (i.e., verbal punishment) would be identified as the interactional behavior sequence that maintains the problem. After identifying the more-of-the-same behaviors and logic system (e.g., bad behavior is corrected with punishment), the therapist then identifies a behavior that represents a 180-degree shift in logic (e.g., cooperative behavior that is motivated by a strong emotional bond).

More-of-the-same solutions can further be described as mishandling the problem in one of three ways (Watzlawick et al., 1974):

- **Terrible simplifications (action is necessary but none is taken):** The client or family attempts to solve the problem by *denying* it: this solution is common with addictions, marital problems, and problematic family dynamics.
- **The utopian syndrome (action is taken when it is not necessary):** The client or family tries to change something that is either unchangeable or nonexistent: this solution is common with depression, anxiety, procrastination, perfectionism, and unrealistic demands on a relationship or a child.
- **Paradox (action is taken at the wrong level):** Either a first-order solution is attempted for a problem that necessitates a second-order solution (e.g., parents are unable to adjust parenting techniques as child matures) or a second-order solution is attempted for a first-order problem (e.g., when people demand attitude or personality changes

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and are not content with behavioral changes). This solution is common with schizophrenia, relational impasses, domestic violence, and abuse.

The Tyranny of Linguistics

When assessing families, the Milan team paid particular attention to the family's word choices and expressions. They were mindful of how language, particularly descriptions of self and others, shape lived reality; they called this the "**tyranny of linguistics**" (Selvini Palazzoli et al., 1978). For example, the statements "I am depressed" and "He's an angry person" are global labels that create little space for noticing numerous moments throughout the day when other feelings and identities may be experienced. Instead, Milan therapists encourage descriptions of a person's *action:* times when I "do" depression or when he is "doing" anger. This subtle shift of words suddenly opens new opportunities for how people experience themselves while also allowing for descriptions of times when the depression is not as strong or a person is not angry.

For Milan therapists, positive labels, such as "intelligent" or "good," are as limiting and problematic as negative descriptors. Like negative descriptions, positive labels obscure the relational context that shapes them (Boscolo et al., 1987). Both positive and negative descriptors are avoided in favor of interactional behavioral descriptions.

Strategic Conceptualization

Madanes (1991) identifies five ways to think about a problem in strategic therapy; these dimensions can be used to conceptualize the role of a symptom in the family system or in an individual's broader social world. One or more of these is used, depending on the case.

- **Involuntary versus voluntary:** Clients generally present by viewing the problem as involuntary; strategic therapists instead view the symptoms as voluntary, with the exception of organic illness. For example, they see arguing, worrying, or being depressed as behaviors or solutions clients choose.
- **Helplessness versus power:** Although symptomatic people appear helpless, their symptoms also generate significant power, allowing them to make otherwise unreasonable demands, receive more care and attention, or excuse otherwise unacceptable behavior. For example, agoraphobia can be seen as an attempt to keep the family close.
- **Metaphorical versus literal:** Symptoms may be viewed as a metaphor for another problem sequence of behaviors in the system. For example, a child's defiance can be seen as a metaphor for the same defiance the husband feels but does not express toward the mother; or bingeing can be seen as a metaphor for rejecting the mother's attempt to overnurture the child.
- **Hierarchy versus equality:** Therapists may conceptualize the presenting problem as a demand for more or less hierarchy, depending on the family's set of circumstances. For example, caving in to a child's tantrums allows the child to be at the top of the power hierarchy.
- **Hostility versus love:** Many family interactions—rejecting a lover because one feels unworthy, disciplining a child, pursuing a partner for sex or communication—can be viewed as motivated by either hostility or love. Strategic therapists may use either interpretation, depending on the therapeutic situation. For example, a husband's constant pursuit of sex may be a sign of love and caring *or* a power move because he feels he has none, depending on the situation. Similarly, a wife's refusal of sex could be motivated by love for husband (e.g., only wanting sex when she really has feelings) or family (e.g., gives too much and is too tired) *or* a power move to gain control because she feels she has none.

Try It Yourself

Find a partner and use the above questions to reframe a relationship problem you have had using one of these strategic conceptualizations.

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Strategic Humanism

The latest developments in strategic therapy emphasize increasing the family's ability to love and nurture rather than dominate and control, which is consonant more generally with the evolution of the field of family therapy (Madanes, 1993). Thus, case conceptualizations focus more on the family's unsuccessful attempts to show love rather than on their attempts to control one another. For example, Jim Keim's (1998) work with oppositional children aims to increase parental nurturing behaviors to help them reestablish a more effective hierarchy, highlighting that a nurturing parent can be as much of an authority as a disciplinarian; once some authority has been reestablished in the nurturing realm, Keim instructs parents to begin enforcing behavioral rules.

The Observation Team

The hallmark of the art of systemic or strategic viewing has always been the **observation team**. Early in the development of these ideas, teams would sit behind a one-way mirror to observe the therapist working with the family. The team could see the systemic dance more rapidly and completely because the person in the room very quickly falls in sync with the family system and has a more difficult time seeing the entire dance. Anyone who has spent time behind a mirror and in front of it knows that you are always smarter behind it. The distance created by not being part of the interactional dance of the family increases one's ability to see the dance more clearly and quickly. Arguably the main reason family therapists still train with a mirror is to develop the ability to see the system's dynamics. This is not to say that a therapist in the room can't see the system's dynamics; it is just harder and takes more practice to do so.

Targeting Change: Goal Setting

Symptom-free Interaction Patterns

Systemic therapists help the family to develop a new set of interaction patterns (i.e., homeostasis), a new game or dance that does not include symptoms (or any subsequent symptoms; Boscolo et al., 1987). Stated yet again, the goal is to create a family homeostasis that is problem-free—or at least does not involve facing the same problem over and over again (Watzlawick et al., 1974).

No Theory of Health

Unlike many earlier schools of therapy, such as psychodynamic or humanistic, systemic therapy does not have a predetermined definition of "healthy family functioning" that the therapist uses to define therapeutic goals. As already stated, therapists do not have a theory of health that defines how the family should look at the end of therapy. Instead, it is believed that the family system (not individual members) will reorganize itself from within to find a "functional," symptom-free interaction pattern in response to the *perturbations* or disruptions introduced by the therapist.

The Problem Is the Attempted Solution (MRI Therapy)

Goals in the MRI brief therapy approach are developed using the following four-step procedure (Watzlawick et al., 1974):

1. **Define the problem:** Use concrete, behavioral terms to describe the actions and reactions of all involved. For example, "My son is always defiant" is not a well-defined problem; a preferred problem description is "When I ask my son to do something, he says 'no' and when I push further he starts yelling and cursing; that's when I give in."

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2. **Identify attempted solutions:** The therapist may ask, "How have you attempted to deal with this problem?" and listens for patterns in the various **attempted solutions** (e.g., threats that are not carried out, negotiating with the child).
3. **Describe the desired behavioral change:** MRI therapists take great care to develop concrete, behavioral goals that meaningfully focus clients' and therapists' attention in useful directions. The goals must be realistic, specific, and time-limited.
   - **Realistic:** Therapists need to be careful to avoid utopian goals, such as "Every time I ask my son to do something, he will obey." Instead, the therapist helps the client develop the more realistic goal of "increasing the frequency with which my son politely carries out my first request."
   - **Specific:** Goals describe clear behaviors and interactions rather than vague intentions, such as "communicate better." As Watzlawick says, "It is the vagueness of goals that make their attainment impossible" (Watzlawick et al., 1974, p. 112).
   - **Time-limited:** MRI brief therapists prefer to set a clear time limit for a specified goal, such as "within 4 weeks."
4. **Develop a plan:** MRI therapists use two basic systemic principles:
   - The target of change is the *attempted solution.*
   - The tactic of change is to use the *client's own language* to speak directly to the client's view of reality.

Thus, the plan is never linear or directive psychoeducation on how to " better communicate." Such plans and interventions are used in cognitive–behavioral therapy (see Chapter 8, not systemic therapy). In dramatic contrast, an MRI systemic approach targets the attempted solution rather than the presenting problem; again, this differs from solution-based therapies, which target the preferred solution (see Chapter 9). Thus, rather than target a child's tantrums by teaching parents how to employ positive and negative reinforcement, systemic therapists identify the class of solutions used by the parents and develop an intervention that represents a 180-degree shift. If the parents respond by becoming embarrassed and giving in, the therapist designs an intervention in which the parents are emotionally unaffected and consistent in carrying out consequences. On the other hand, if the parents typically respond with strict, harsh punishment, the therapist suggests an emotionally engaged and gentle approach.

Strategic Goals

> *The main goal of therapy is to get people to behave differently and so to have different subjective experiences. —Haley, 1987, p. 56*

Strategic therapy does not have a predefined set of long-term goals for individual or family functioning, other than to promote a change that alters people's subjective experiences (mood, thoughts, and behaviors). Madanes (1990, 1991) conceptualizes all problems brought to therapy as stemming from an existential dilemma between love and violence, because these two experiences tend to be closely correlated in human affairs. Thus, the ultimate strategic goal is to help clients find ways to love without dominating, intruding upon, or harming the other. This goal may be achieved by doing the following (Madanes, 1991):

- Correcting the couple or family hierarchy (either increasing or decreasing it)
- Reducing intrusion or increasing engagement by changing a parent or partner's level of involvement
- Reuniting family members
- Changing who is helpful and how, including empowering children to be appropriately helpful
- Repenting for an injustice and forgiving
- Increasing the expression of compassion and unity

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The Doing: Language-Based Interventions

Systemic Reframing; Circular Questions (see Juice)

This intervention is described in detail in "The Juice" section, above.

The Hypothesizing Process (Milan Therapy)

> *The construction of hypotheses is a continuous process, coevolving with the family's movement. The act of* ***hypothesizing*** *is best described using the concepts of cybernetic feedback loops, for as the family's response to the question modifies or alters one hypothesis, another is formed based on the specifics of that new feedback. This continuous process of hypothesis construction requires the therapist to reconceptualize constantly, both as an interviewer and team member.—Boscolo et al., 1987, p. 94*

The process of generating a hypothesis, emphasized in the Milan approach, continues throughout therapy and generally has the following two phases:

1. **Hypothesizing for conceptualization:** This is the behind-the-mirror process of developing and revising hypotheses that the therapist and team use to guide their "viewing" and provide an overall focus and direction for therapy.
2. **Hypothesizing as intervention:** When the therapist and team believe it will benefit the family, the hypothesis they have been developing behind the mirror is shared verbally with the family as an in-session intervention.

As already discussed, a hypothesis usually defines the role of the symptom in maintaining the family's homeostasis (Boscolo et al., 1987). For example, a teen's delinquent behavior may serve to bring the parents closer together; without the child's "problem" behavior, the couple might experience other difficulties that would be harder for the family to manage. Hypotheses can also highlight how the family wants to simultaneously keep things the same and change, two counterbalancing forces. When therapists deliver hypotheses to the family, the purpose is to "create news of a difference" and shift how they think about the problem, thus creating new possibilities for change. Hypotheses need to be worded so that they are different from how the family is currently viewing the situation yet not so different that they react against it. Instead, hypotheses need to be *plausible* in the family's current worldview (Watzlawick et al., 1974).

The Milan team identified three common types of hypotheses (Boscolo et al., 1987):

- **Hypotheses about alliances:** These describe alliances and coalitions: who is on whose team.
- **Hypotheses about myths and premises:** These identify unrealistic or problematic myths and premises that are contributing to the problem (myths of the perfect marriage, ideal child, etc.).
- **Hypotheses that analyze communication:** These track problematic communication patterns, such as double binds.

Positive Connotation: The Milan Reframe

Milan therapists originally developed **positive connotations** to not contradict themselves when prescribing **paradoxical interventions** (Selvini Palazzoli et al., 1978). Therapists use positive connotation to respect both the family's fear of change and their request for change. They interpret the behavior of each member of the family positively, as having an underlying benevolent motivation (Boscolo et al., 1987). A common positive connotation is reframing a child's problematic behavior as a way to keep the parents together and reframing the parents' arguments about how to handle this behavior as a way to show their dedication to the family and each other. Perhaps the most important outcome of positive connotation is the effect it has on the therapist, enabling the therapist to view members of the system less judgmentally and with greater hope.

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Try It Yourself

Create a positive reframe for a relational problem experienced by you or a friend.

The Therapeutic Double Bind and Counterparadox (MRI and Milan, respectively)

The MRI therapeutic double bind is used to undo a double-bind message in a family or relationship; similarly, the Milan counterparadox is used to therapeutically respond to the paradoxes, or double binds, that families and couples create for themselves (Selvini Palazzoli et al., 1978; Watzlawick et al., 1967). The difference between a problem-generating double bind and a therapeutic double bind is simple: in the problem-generating form, no matter what you do, you are wrong; there is no escape. In a therapeutic double bind or counterparadox, no matter what you do, you do something different, something that moves you in a new direction.

A common double bind is when one party demands that the other spontaneously display love and affection. For example, a wife may demand that her husband spontaneously express his love in more romantic ways: flowers, candlelight dinners, and gifts. If he does what she asks, she can say that he only did it because she asked and that it wasn't spontaneous; if he does not do anything romantic, then she can say he obviously doesn't care because he didn't follow through. Either way he loses. A therapeutic double bind would be to have him show his romantic side in any way other than the specific ways his wife demands. If he follows this directive literally, he will initiate new romantic behavior in the system; if he does not follow the instructions and instead chooses to use one of his wife's suggestions, then he is doing so without the command to do so. If you think it is tough to design such an intervention on your own, you are right—that is why the early family therapists preferred to work in teams. They could then more quickly assess the family's double binds and identify helpful therapeutic paradoxes.

Invariant Prescriptions (Milan Therapy)

One of the Selvini Palazzoli's earliest therapeutic innovations and the focus of her long-term research, the **invariant prescription** is just what it sounds like: an intervention that is not varied across families (Selvini Palazzoli, 1988). Used primarily with families whose children are labeled anorexic or schizophrenic, the intervention severs covert coalitions between a parent and a child. Parents are instructed to arrange to go on a date (or other outing) and to not tell the children where they are going or why. The desired effect is to create a secret between the parents, ending inappropriate coalitions by creating a clear boundary between the parents as a unified team and the symptomatic child. The child loses the status of being a special confidant of the one parent, lessening his/her emotional burden and resulting in fewer problem symptoms. Although originally designed for severe pathology such as anorexia and psychosis, this intervention is also effective with modern parents who overemphasize transparent and open communication with their children to the extent that the children use this information to "manipulate" them. The therapist in this chapter's case study uses a variation of this technique with 16-year-old Alba, who is acting out after her parents separate; the invariant prescription helps restore the parental alliance so that Alba does not feel the "systemic pull" to act out to get her parents to work together.

Dangers of Improvement (MRI and Strategic Therapy)

A technique used by MRI and strategic therapists, the *dangers of improvement* involves asking clients to identify potential problems that might arise if the problem were resolved (Segal, 1991). For example, if a child becomes more independent in doing homework and

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getting chores done, what will the mother and father do to feel that they are parenting their child? If a couple suddenly stops arguing, how will they keep the flame of passion alive in their relationship? If a person stops being depressed and starts socializing again, how will he protect his solitude and quiet time? These questions undermine unrealistic and utopian worldviews that not only created the current problem but are also likely to be the source of new problems to come.

Restraining, Going Slow

Restraining or the directive to *go slow* is another common systemic and strategic intervention that carries a paradoxical flavor (Segal, 1991). When therapists restrain or instruct clients to go slow, they warn clients to avoid changing too fast and encourage them to take change slowly. This has a paradoxical effect similar to a therapeutic double bind in that if the client complies, change will happen and the client will be better prepared for the setbacks that characterize most attempts at change. On the other hand, if the client has a rebellious response, he or she will attempt to rebel against slowness by working harder toward desired change. In either case, the change process is supported and "immunized" against setbacks.

Deconstructive TIPs (Transforming Interpersonal Patterns)

Using Tomm's IPscope approach, Gaete and colleagues (2014) distinguish between two types of transforming interpersonal patterns (TIPs) that therapists can use to facilitate change: deconstructive and constructive TIPs. Deconstructive TIPs involve asking clients questions that invite them to reconsider their assumptions related to the problem. Typically, this process involves questioning their individualistic perspective and moving toward a more relational view of the situation. Therapists can do this by asking questions that help clients explore how their behavior and responses may—unintentionally—perpetuate the pathologizing interpersonal pattern (PIP), such as "what do you think your partner is thinking when you begin to raise the issue?" In addition, therapists can explore sociocultural patterns (SCIPs) that may help clients to shift assumptions that fuel the PIP. For example, a therapist could ask about the division of labor for a dual-career couple and explore gender discourses that may be reinforcing an unfair division of labor. Furthermore, circular questions and systemic reframing can also be used to deconstruct meanings that perpetuate the PIP. When working with a relationship in which there is a significant power difference, the therapist begins deconstructive TIPs by directing questions at the more powerful person, which is similar to the socioemotional relational therapy methods described in Chapter 3. Regardless of the exact method, therapists using the IPscope are careful to track the interpersonal pattern related to the TIP to ensure that their action has the intended helpful effect. If not, the therapist addresses this issue with the clients respectfully, directly, and immediately and with the attitude that the therapist will work to correct the misunderstanding.

The Doing: Action-Oriented Interventions

Directives (MRI and Strategic Therapy; also See Directives in Juice Section Above)

Used in both strategic and MRI approaches, directives are behavioral tasks that the therapist gives to clients to alter their interaction patterns. Haley (1987) identifies two general types of directives: straightforward and indirect. **Straightforward directives** are used when the therapist has the power and influence to get people to do what is asked; **indirect directives** are used when the therapist has less authority in the eyes of the client. Indirect directives generally take the form of paradoxical or metaphorical tasks.

Technically, straightforward directives mean giving good advice, but Haley is quick to admonish against them: "Giving good advice means the therapist assumes that people have rational control of what they are doing. To be successful in the therapy business, it may be better to drop that idea" (Haley, 1987, p. 61). Therefore, most straightforward

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directives aim to change the way the family interacts by introducing *new action*. Often therapists are tempted to ask clients to stop doing something; Haley warns against this also: "If the therapist tells someone to stop usual behavior, he must usually go to an extreme or get other family members to cooperate and change their behavior" (p. 60). Thus, most strategic directives *resequence* interaction patterns by requesting small behavioral or contextual changes, such as having the other parent discipline a child who has broken house rules or asking a couple to add a 10-second pause between exchanges in a fight. These smaller changes are much easier to accomplish. The differences between straightforward and indirect directives are outlined in the following table.

THERAPEUTIC DIRECTIVES

	Straightforward Directives	Indirect Directives
Type of task	• Do something different: alter behavioral sequence • Stop a behavior (rarely used) • Good advice; psychoeducation (rarely if ever used)	• Paradoxical tasks • Metaphorical tasks
Type of therapeutic relationship	• Therapist has influence; well accepted as expert	• Therapist less well accepted as expert
Type of problem	• Client able to feel control over small behaviors requested as part of task	• Client feels he or she has very little control

Straightforward Directives

Haley maintained that "the best task is one that uses the presenting problem to make a structural change in the family" (1987, p. 85). Designing straightforward directives involves several steps:

1. **Assess the situation:** The therapist identifies the interaction sequence of behaviors that constitute the presenting problem; for example, the child comes home after curfew, the father angrily enforces a harsh punishment, and the mother defends the child to the husband and does not enforce the punishment.
2. **Target a small sequence change:** The therapist finds one small behavioral change in the sequence that the family can reasonably make that would alter the problem sequence; for example, have the mother enforce the curfew, or have the daughter propose a "fair" punishment for breaking curfew.
3. **Motivate the family:** Haley (1987) emphasizes the importance of motivating the family *before* the task is issued. For straightforward tasks this is usually done by appealing to the shared goal: begin by first talking about how everyone wants the problem behavior to stop: "Everyone agrees that they want the arguing at home to stop."
4. **Give precise, doable instructions for the directive:** When describing the task, the therapist needs to be extremely precise—when, where, how, who, on which day of the week—while accounting for weekend changes in schedules, weekday homemaking tasks, and special events during the week that the task is assigned. Tasks should be clearly *given* rather than suggested: "Next week, when Susan comes in late from curfew or breaks any other house rule, mom, I want you to enforce the consequences, and dad, you are not to be part of the discussion with Susan and your wife. If you need to discuss what happened, you will discuss it with your wife alone."

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5. **Review the task:** The therapist asks the family members to repeat their parts: "Just to review and make sure we all understand, can each of you tell me what you are going to do this week?"
6. **Request a task report:** The following week, the therapist asks the family how it went. Generally, one of three things happens: (a) they did it, (b) they didn't do it, or (c) they partially did it (Haley, 1987). If clients completed the task, they are congratulated. If they partially did the task, the therapist does not excuse them too quickly because that would send a message that undermines the therapist's authority. If they failed to attempt the task, Haley uses two responses, one nice and one not so nice. In the nice response, the therapist says, "I must have misunderstood you or your situation to ask that of you—otherwise you would have done it" (1987, p. 71). In the not-so-nice approach, the therapist emphasizes that the family has missed an opportunity to make changes for their own good and that this is a failure and a loss for them (not that they disappointed the therapist); the therapist does not ask them to redo the task even if they say they want to. Instead, the therapist uses this experience to increase motivation for the next task.

Indirect Directives: Paradoxical Interventions (MRI, Milan, and Strategic Therapies)

Perhaps the most misunderstood of strategic and systemic interventions, *paradoxical intervention,* also called *symptom prescription,* involves instructing clients to engage in the problem behavior in some fashion, such as by assigning a couple to argue from 7:00 to 7:15 on Tuesday and Thursday. Symptom prescription and other paradoxical interventions are "paradoxical" because they do not follow linear logic—at least at first blush. You will know when it is time to use one of these because when it is appropriate to use paradox it will not seem paradoxical—at least in the mind of the therapist—it will be the only logical, obvious action to take. Paradox makes sense with two general types of problems: (a) when making any other therapeutic changes disrupts the family's current level of stability or (b) when the problem seems "uncontrollable" from the client's perspective: I can't keep myself from worrying, nagging, eating, fighting, etc.

Paradox with Families That Avoid Change

When family members stabilize around one member being the problem, they are often resistant to the therapist's attempts to change that perception because it may create more discomfort than they are currently experiencing; in these situations paradox can be useful (Haley, 1987). The therapist may restrain or caution against certain changes: "Perhaps you need to argue to keep your passion strong; if you stopped, things might get worse." Or the therapist might choose to paradoxically encourage relapse to prevent it (Haley, 1976). Paradoxical tasks are difficult to deliver because the therapist must communicate several messages at once:

- I want to help you resolve your problem.
- I am sincerely concerned about you.
- I think you can be normal, but perhaps you cannot be.

When paradox is successful, change is usually spontaneous.

Paradox with Uncontrollable Symptoms

If clients have symptoms that they claim they absolutely cannot control, it makes sense to use *symptom prescription* as an intervention. Symptom prescription changes the *context* of the problem behavior. If the context changes, the *meaning* of the behavior must change. When the meaning changes, thoughts, feelings, and subsequent behaviors automatically change also. A common example is using paradox for worrying, which is particularly difficult to treat because it is a cognitive and emotional process that often has few associated behaviors. When clients are given the directive to set an egg timer and worry

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for 10 minutes at a particular time in the day, worrying radically changes from a vague, free-floating experience to a consciously chosen activity that they can voluntarily start and, most often they quickly discover, can also stop at will. When the context is changed, the meaning and experience of worrying change, often creating significant movement on a symptom that seemed totally out of the client's control.

Indirect Directives: Metaphorical Tasks (Strategic Therapy)

Inspired by Milton Erickson's trance work and therapeutic style, the metaphoric task is used when it is not appropriate to explicitly address a problem (Haley, 1987). Haley believes that metaphors need to be acted on, not just talked about, to create change. Metaphoric tasks involve four stages:

1. The therapist identifies an area of the client's life with dynamics similar to those of an area the therapist wants to change (e.g., discussing adopting a pet with a child who has been adopted).
2. The therapist uses a story or conversation to discuss how adoption works (e.g., what happens when the dog gets sick).
3. The therapist takes a position about how things should change in the metaphoric area (e.g., child is ready to adopt first pet).
4. A task is usually assigned in the metaphoric area (e.g., child's parents are encouraged to help him adopt a pet).

Pretend Techniques (Strategic Therapy)

"Fake it 'til you make it" sums up the spirit of **pretend techniques**, used principally by strategic therapists. In these techniques, clients are asked to "pretend" they have achieved their goal for a designated period of time (from minutes to days) to help make their desired changes. When they fake a behavior, even for a short period of time, often there is a genuine change in perspective, feeling, or behaviors. For example, when a couple is asked to fake being in love for an evening, they often feel those genuine feelings return. Systemically, this technique works by triggering old, preferred interaction patterns that are already there or, if this is an entirely new behavior, by creating new interaction sequences that are now available within the system. In either case, brief periods of pretending introduce new interactional sequences, creating new options for behavioral, emotional, and cognitive change.

Ordeals (Strategic Therapy)

Inspired by the work of Milton Erickson, **ordeals** are often used in strategic therapy when the client feels helpless in controlling a symptom such as overeating, smoking, nail biting, and drinking. They are based on a simple premise: "If one makes it more difficult for a person to have a symptom than to give it up, the person will give up the symptom" (Haley, 1984, p. 5). Rather than try to develop linear, logical means for stopping the behavior (that would be a cognitive–behavioral approach), the strategic therapist allows the symptom with a twist: the client must complete another task, an "ordeal," before or after the symptom.

The ordeal need not be directly related to the undesired activity, but it often has a metaphoric relation to it. For example, if a person is trying to reduce his/her "emotional eating" to soothe difficult emotions, the ordeal would target the behavior and internal tension in either a linear or logical way (e.g., engage in a favorite hobby, write in a journal) or in an indirect or nonlogical way (e.g., perform a random act of kindness for a stranger or loved one, clean the house). In most cases, ordeal therapy is less about creating a horrific, unappealing ordeal to stop undesired behavior and more about shaking up or perturbing the systemic pattern so that new behavioral sequences can evolve. To return to the family dance metaphor, the ordeal isn't a behavioral deterrent or punishment as much as a new piece of furniture in the middle of the dance floor that forces the

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system to make changes to navigate around it. As the system adjusts to this rather small and innocuous twist, it must change to create new steps and is able to do so with less fear and resistance than if it were told to stop dancing its favorite (or at least best-rehearsed) dance.

Constructive Transforming Interpersonal Patterns (TIPs)

Constructive transforming interpersonal patterns (TIPs) involve therapists and clients actively working together to identify and enact healing interpersonal patterns (HIPs) and wellness interpersonal patterns (WIPs; Gaete et al., 2014). Therapists can identify what might constitute healing or wellness patterns in at least two ways: (a) by listening carefully to what clients say spontaneously, and (b) by directly asking for their clients' thoughts. For example, if when discussing the PIP, a client naturally offers a description of how he would prefer to interact ("I wish I could be more emotionally attuned to her"), the therapist can start with this description and follow up with questions about what that might look like to begin identifying what type of interactional pattern would have meaning for the couple.

Internalized-Other Interviewing

Arguably a systemic version of the classic Gestalt empty chair technique, Tomm (1999) developed **internalized-other interviewing** to help clients generate a more relational perspective associated with the presenting problem and help in generating HIPs. As described in Chapter 3, Tomm conceptualizes relationships not just with physical others but also with our internal representations of these others. For many of us, we spend as much relating to the image of our partners, parents, children and friends as we do to the actual people. This internalized-other interview can be helpful in multiple ways, including generating compassion for and understanding of the other's reality, identifying assumptions and inaccuracies that may be fueling the PIP, and inspiring greater relational responsibility. The therapist begins by asking clients about their willingness to participate in the interview and then speaking to the client literally *as if* the client is the other (e.g., using his/her name, second person "you"). The therapist also emphasizes that the client is speaking from his/her internalized other rather than trying to pretend to be the other person; this is particularly important if the other person is in the room. The questions asked during internalized-other interviewing are designed to help the client explore the interactional patterns in greater depth. For example, clients may ask the internalized other, "When your partner (the client who is speaking) shuts down and will not continue the conversation, what is that like for you? Which part of this did you share with your partner? What didn't you share? Why?" Through this process, clients begin to develop new perspectives that help move toward WIPs and HIPs. Tomm cautions that this approach can make clients feel very vulnerable, and therapists should be compassionate and gentle during the process (Tomm, 1999; Tomm, Hoyt, & Madigan, 1998). He also notes that this process can be challenging if the client misunderstands and tries to be the literal other or if the client gives the answers he/she wishes the other person would say.

Burnham (2000) recommends the following steps to this interview process:

Internalized-Other Interviewing

1. Choose the person, problem, or emotion to be explored.
2. Introduce internalized-other interviewing and describe how it could be helpful to the client's specific situation.
3. Begin by "grounding" the person being interviewed in the identity of the other by using the other's name and asking nonthreatening questions about daily life, job, etc.
4. Move on to ask questions about how the internalized other experiences the problem situation, including how he/she experiences the client speaking in these interactions.

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This process can be used in multiple ways, including interviewing:

- Multiple internalized others within one person
- The same internalized other in several people
- The internalized other of the other
- A problem, belief, emotion, or diagnosis as an internalized other

Scope It Out: Cross-Theoretical Comparison

Using Tomm's IPscope described in Chapter 3 (Tomm et al., 2014), this theory approaches the conceptualization of systemic, interpersonal patterns as discussed below.

Case Conceptualization

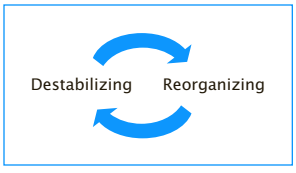
The quintessential systemic approach, classic systemic–strategic therapists conceptualize their work by focusing almost exclusively on pathologizing interpersonal patterns (PIPs). Systemic–strategic therapists begin tracking the PIP by mapping the behavioral sequence that constitutes the pattern, following the interactions from the beginning of symptoms (positive feedback) back to homeostasis, carefully tracking each person's role in the system. Then they step back and identify the more basic complementary pattern, which they can do by identifying "more of the same solutions," strategic conceptualization of power and love, the tyranny of linguistics, or another method for systemically conceptualizing the fundamental dynamic. Obviously, therapists using Tomm's IPscope approach conceptualize treatment using all possible IPs.

Goal Setting

Systemic–strategic therapists do not use a theory of health to guide their work. Instead, they trust that in response to their interventions or "perturbing" of the system, the system will create WIPs that are most appropriate and work best for them. Essentially, their goal is for the client or family to no longer have PIPs, and virtually any WIP that allows for all members to be symptom-free is an acceptable goal. For therapists working primarily from Tomm's IPscope, their focus is typically on identifying potential HIPs, which are targeted during the working phase of therapy and then finally they set their goals on stabilizing WIPs for the closing phase.

Facilitating Change

Whether action-based or language-based, virtually all interventions or transformative interpersonal patterns (TIPs) used by traditional systemic—strategic therapists have a single intention: interrupt the PIP. The fundament TIP between therapist and client could be described as shown here:



All interventions are intended to destabilize the PIP in some way, either by introducing new interpretations (e.g., a reframe) or new behaviors (e.g., directives). These destabilizing TIPs require the client/family to respond to something new, thereby organizing their interpretations or behavior in a new way. This process continues until WIPs are stabilized and PIPs are no longer enacted. Therapists using Tomm's IPscope facilitate change by using deconstructive (e.g., challenging client constructions of the

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problem, etc.) and constructive (e.g., identifying new action) TIPs to help clients enact HIPs and WIPs.

Putting It All Together: Systemic–Strategic Case Conceptualization and Treatment Plan Templates

Areas for Theory-Specific Case Conceptualization: Systemic–Strategic

When conceptualizing client cases, contemporary systemic–strategic therapists typically use the following dynamics to inform their treatment plan. You can download a digital version of the theory-specific case conceptualization on MindTap or at www.masteringcompetencies.com.

Pathologizing Interpersonal Pattern

Describe dynamic of primary PIP (**PIPs; A ⇆ B**):

☐ Pursuing/Distancing ☐ Criticizing/Defending ☐ Controlling/Resisting ☐ Other:___
Describe Start of Tension: _____
Describe Conflict/Symptom Escalation: _____
Describe Return to "Normal"/Homeostasis: _____

What is the metacommunication (how is each attempting to define the relationship) in this interaction? _____

Family Life Cycle

Identify client's phase of family life cycle; include all that apply:

- Single adult
- Committed couple
- Family with young children
- Family with adolescent children
- Divorce
- Blended family
- Launching children
- Later life

Describe struggles with mastering developmental tasks in one or more of the following stages.

Attempted Solutions

List attempted solutions that DIDN'T work:

Complementary Roles

Complementary patterns between _____ and _____:

- Pursuer/distancer
- Overfunctioner/underfunctioner
- Emotional/logical
- Good/bad parent

Hypothesis: Role of Symptom in System

Hypothesize the homeostatic function of presenting problem. How might the symptom serve to maintain connection, create independence/distance, establish influence, reestablish connection, or otherwise help create a sense of balance in the family?

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Sociocultural Patterns

Describe how sociocultural factors and issues of power and marginalization inform the problem interaction cycle (e.g., cultural, gender, immigration status, economic class, sexual/gender orientation, religion, ability).

Treatment Plan Template for Individual with Depression/Anxiety: Systemic–Strategic

You can download a blank treatment plan (with or without measures) at www.Cengage.com/MindTap (MindTap account required) or www.masteringcompetencies.com. The following treatment plan template can be used to help you develop individualized treatments for use with individuals with depressive or anxiety symptoms.

Systemic–Strategic Treatment Plan: Client Goals with Interventions

Early-Phase Client Goal

1. Increase possibilities for reframing and systemically viewing the problem to reduce depressed mood/anxiety.
   a. Reframe problem in relational context to shift meaning of symptoms.
   b. Circular questions to enable client to see systemic interaction cycle and client's role in it.

Working-Phase Client Goals

1. Reduce client's sense of seeming helplessness related to [presenting symptoms] to reduce depression and anxiety.
   a. Paradoxical tasks that exaggerate helplessness and reveal hidden benefits.
   b. Deliver hypothesis to client that reframes symptoms from a systemic perspective, highlighting how each person's behavior is contextualized by other's.
2. Reduce and disrupt frequency of pathologizing interpersonal and intrapersonal patterns to reduce depression and anxiety.
   a. Circular questions to identify differences, see behavioral sequences, and consider hypothetical situations to shift meaning associated with problem behaviors and how they fit into relational patterns.
   b. Paradoxical behavioral prescriptions that require client to enact particular depression symptoms at specific times to interrupt problem behavior sequence.
3. Increase frequency of wellness interpersonal and intrapersonal patterns to reduce depression and anxiety.
   a. Directives that instruct client to make a small but meaningful alternation to symptom pattern.
   b. Behavioral prescription that represents a 180-degree shift to attempted solutions.

Closing-Phase Client Goals

1. Increase effectiveness of relational interaction patterns with partner/family to reduce potential for relapse of depression and anxiety.
   a. Rituals that reinforce new patterns
   b. Behavioral prescription to have client slightly but meaningfully alter his/her half of problem interactions with others.

Treatment Tasks

1. Develop working therapeutic relationship using theory of choice.
   a. **Respect and trust the system** while **adapting client language** and maintaining therapeutic **maneuverability**.
2. Assess individual, relational, community, and broader cultural dynamics using theory of choice.

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   a. Assess the interactional sequence(s) related to the problem, including rise of tension, symptom, return to homeostasis, metacommunication, and complementary patterns; identify stage of family life cycle.
   b. Conceptualize problem using one or more systemic–strategic frames, such as more-of-the-same solutions, voluntariness, helplessness, hierarchy, love, etc.

3. Identify needed referrals, crisis issues, collateral contacts, and other client needs.
   a. *Crisis assessment intervention(s):* Address crisis issues such as self-harm, suicidal ideation, substance use, risky sexual behavior, etc.
   b. *Referral(s):* Connect client with **resources** in client's **community** that could be supportive; make collateral contacts as needed.

Treatment Plan Template for Couple/Family Conflict: Systemic–Strategic

You can download a blank treatment plan (with or without measures) at www.cengagebrain.com or www.masteringcompetencies.com. The following treatment plan template can be used to help you develop individualized treatments for use with couples and families who report relational distress.

Systemic–Strategic Treatment Plan: Client Goals with Interventions

Early-Phase Client Goal

1. Increase possibilities for systematically viewing relational conflict and each person's role in it to reduce conflict.

   Interventions:
   a. Strategic reframing that recharacterizes each person's role in the interaction as having an ultimate, underlying motivation of love.
   b. Circular questions to enable clients to see systemic interaction cycle and each person's role in it.

Working-Phase Client Goals

1. Reduce frequency of and disrupt pathologizing interpersonal patterns to reduce conflict.

   Interventions:
   a. Circular questions to identify differences, see behavioral sequences, and consider hypothetical situations to shift meaning associated with problem behaviors and how they fit into relational patterns.
   b. Behavioral prescriptions that interrupt conflict by altering the where, when, how, and who of the conflict.

2. Increase frequency of wellness interpersonal patterns that enable couple/family to [identify specific problem: such as solve problems effectively] to reduce sense of emotional isolation.

   Interventions:
   a. Directives that instruct client to make a small but meaningful alternation to symptom pattern.
   b. Ordeal therapy that alters sequence of behaviors related to couple/family conflict.

3. Increase frequency of wellness interpersonal patterns that enable couple/family to [identify specific problem: such as experience intimacy] to reduce sense of emotional isolation.

   Interventions:
   a. Directives that instruct client to make a small but meaningful alternation to symptom pattern.

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b. Metaphorical tasks that make overt the covert power associated with being symptomatic.

Closing-Phase Client Goals

1. Increase ability to see how **love** motivates own and other's behaviors in the relationship to increase sense of wellbeing and connection.
   a. **Reframe problem interactions** focusing on how love motivates interactions, even problem interactions.
   b. **Directives/metaphorical tasks** designed to highlight the hidden motivation of love.
2. Increase ability to [complete developmental tasks] for **family life stage** to reduce chance of relapse.
   a. **Directives** designed to rebalance independence and interdependence based on stage of family life.
   b. **Pretend techniques** to help master new developmental challenges.

Treatment Task

1. Develop working therapeutic relationship using theory of choice.
   a. **Respect and trust the system** while **adapting client language** and maintaining therapeutic **maneuverability**.
2. Assess individual, relational, community, and broader cultural dynamics using theory of choice.
   a. Assess the interactional sequence(s) related to the problem, including rise of tension, symptom, return to homeostasis, metacommunication, and complementary patterns; identify stage of family life cycle.
   b. Conceptualize problem using one or more systemic–strategic frames, such as more-of-the-same solutions, voluntariness, helplessness, hierarchy, love, etc.
3. Identify needed referrals, crisis issues, collateral contacts, and other client needs.
   a. *Crisis assessment intervention(s):* Address crisis issues such as psychological abuse, intimate partner violence, hidden affair, self-harm, suicidal ideation, substance use, etc.
   b. *Referral(s):* Connect client with **resources** in client's **family and community** that could be supportive; make collateral contacts as needed.

Tapestry Weaving: Diversity Considerations

Ethnic, Racial, and Cultural Diversity

Because systemic and strategic family therapies do not rely on a theory-based definition of health and normalcy, they adapt relatively easily to different cultural groups and subpopulations: "Since in strategic family therapy a specific therapeutic plan is designed for each problem, there are no contraindications in terms of patient selection and suitability" (Madanes, 1991, p. 396). Furthermore, drawing on systemic and constructivist foundations, these therapies aim to work from *within* the client's worldview; when this is successfully achieved, the therapist adapts the language and interventions to the client's values and beliefs.

Of particular interest, two groups of systemic therapists have systematically adapted and used the approach with Latino/Hispanic clients. The Latino Brief Therapy Center at the MRI uses the nonnormative and nonpathologizing principles of the model to guide its work, creating unique meaning and interventions with each client, rather than rely on cultural stereotypes of the extremely diverse Latino community (Anger-Díaz, Schlanger, Rincon, & Mendoza, 2004). Similarly, Brief Strategic Family Therapy, an evidence-based approach that uses elements of systemic and structural family therapies (see Chapter 5 for a detailed description), was developed specifically to treat Hispanic youth with high-risk

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behaviors and substance use issues; the approach has also been found to be effective with African American youth (Robbins, Horigian, Szapocznik, & Ucha, 2010; Santisteban et al., 1997).

In addition to these specific treatment approaches, McGoldrick, Giordano, and Garcia-Preto (2005) provide descriptions of how systemic ideas and approaches can be modified to meet the needs families from 46 different ethnicities, an invaluable resource when working with cultural groups other than one's own (and perhaps your own; read and see). Although these descriptions must be general and do not capture the unique lived experience of a particular client who may be in front of you at a given moment, they can give the therapist a clue about how best to understand and engage the client (and most clients appreciate you having at least a clue about their background as well as giving them room to share their own unique experience and beliefs). The case study at the end of this chapter illustrates how a systemic approach can be used with a second-generation Catholic Mexican American family whose teenage daughter has begun smoking pot and drinking.

Sexual and Gender Identity Diversity

Because of its nonpathologizing and nonnormative assumptions and its attention to larger systemic dynamics, systemic therapies have been widely used with clients who identify as lesbian, gay, bisexual, transgendered, or questioning (LGBTQ). Butler (2009) identifies five principles for adapting systemic therapy approaches for these clients.

1. *Understanding heterosexism:* Therapists need to be aware that gender and sexual minorities have *daily* experiences of being marginalized, judged, and ignored and rarely see their reality reflected in advertisements, movies, and other social forums.
2. *Therapist self-reflectivity:* Heterosexual therapists need to engage in personal self-reflection of their experience of being privileged and having their sexual and gender orientations generally approved by society.
3. *Locating your position, transparency, and self-disclosure:* Based on the work of feminist therapists, Butler recommends disclosing one's gender and sexual orientation when working with LGBTQ clients. Such openness allows for frank discussions about areas of similarity and differences, helping to address issue of power and hierarchy. However, too much self-disclosure can be nonproductive.
4. *Client as expert, and therapist as curious.* Drawing upon collaborative therapy principles (see Chapter 10), therapists should assume a curious stance, viewing clients as the experts in their lives and lifestyles.
5. *Connecting to wider systems:* Finally, therapists should consider the larger social systems of which their LGBTQ clients are a part and encourage them to seek positive, supportive communities.

Butler (2009) also discusses how therapists need to adjust their approach with LGBTQ couples. First, therapists should be aware that sex, gender roles, monogamy, family of origin, family of choice, and expartners generally have very different meanings with these couples. Furthermore, gender roles are thought to have more impact than sexual orientation per se in these relationships, with internalized gender roles often greatly restricting same-sex relationships and being a particular issue in couples with a transgendered partner. Therapists can help couples to deconstruct their gender-role expectations and assumptions in ways that strengthen the partnership. Finally, therapists should keep in mind that the family life cycle looks different for most LGBTQ individuals, couples, and families (Golden, 2009).

Adolescents Coming Out to Family

Another common issue that family therapists address is adolescents coming out to their families (Butler, 2009). First and foremost, therapists should be aware that gay, lesbian, bisexual, and transgendered youth have higher rates of suicidality, substance abuse,

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self-harm, depression, anxiety, and school issues, so it is important to monitor the adolescent's safety and address these issues. Before coming out, most adolescents are generally able to accurately predict their parents' responses based on casual comments about sexuality over the years. Therapists can use DeVine's (1984) stage theory for the family's process of coming out to help families negotiate this transition.

- *Subliminal awareness:* The child's sexuality is suspected and sometimes provoked by inquiries about dating and same-sex friendships.
- *Impact:* The child announces his/her sexuality and suspicions are confirmed.
- *Adjustment:* The family struggles to maintain its old homeostasis, while the child is expected to hide or deny his/her sexuality.
- *Resolution:* The family comes to accept the child's sexuality identity.
- *Integration:* The family shifts their values related to gender and sexual norms.

Many parents whose child comes out report a "loss" of their dreams of having a wedding or grandchildren, and much of their initial response may actually reflect the personal losses they are projecting. Therapists can help redirect parents to focus on their child's real needs at this time while also developing a more hopeful view of their future family life.

Transgendered Youth

There is little research or literature to guide therapists when working with transgendered persons, especially youth. However, unlike gay, lesbian, and bisexual youth, transgendered youth often cannot hide their difference, and thus it is more likely to be a point of family discussion, whether the child wants it public or not (Coolhart, Baker, Farmer, Malaney, & Shipman, 2013). The majority of transgendered youth (59%) report negative parental reactions to their gender identity, at least initially, with those who are more gender-nonconforming reporting greater conflict with parents (Grossman, D'Augelli, Howell, & Hubbard, 2005). However, parental acceptance is important for transgendered individuals and is correlated with adult life satisfaction and self-esteem (Erich, Tittsworth, Dykes, & Cabuses, 2008).

Coolhart and colleagues (2013) outline an assessment tool for therapists working with transgendered youth and their family. They recommend working with the family of transgendered youth whenever possible, attending to systemic dynamics. The assessment tool consists of questions that cover the following nine domains:

- *Early awareness and family context:* These questions address the general family structure and history as well as both parents' and youth's early gender experiences. For example: "Please provide additional information about how your family's context in terms of racial, ethnic, and national communities interfaces with beliefs about variant expressions of gender and sexuality" (p. 16).
- *Parents' attunement with youth's affirmed gender:* These questions address how the parents and family have responded to the youth's transgender identity. For example: "When your child disclosed (or you discovered) their transgender identity, what was this experience like for you individually, as a couple, and as a family as a whole?" (p. 17).
- *Current gender expression:* These questions address the youth's current preference for expressing gender. For example: "Have you dressed privately in clothing typically associated with your affirmed gender? When did you first begin to dress in private? How did it feel when you first began to dress in private? Did anyone else know? If so, what was their reaction?" (p. 17).
- *School context*: These questions explore the youth's experience and possible harassment at school related to gender identity. For example: "What is your current gender expression at school? Are you 'out' to any of your friends?" (p. 18).
- *Sexual relationships/development:* These questions are typically asked of the youth in private and address sexual orientation, abuse, and activity. For example: "How do

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you identify your sexual orientation? Have you ever experienced or witnessed sexual or physical abuse?" (p. 19).

- *Current intimate relationship(s):* If the youth is involved in a current relationship, the therapist inquires about the relationship and the partner's knowledge of the youth's gender identity and possible interest in transitioning.
- *Physical and mental health:* These questions assess for physical and mental health issues that may need addressing, including the potential for self-harm and substance abuse.
- *Support:* These questions aim to identify sources of support for the family and youth, including family, friends, church, neighbors, support groups, Internet connections, etc.
- *Future plans/expectations:* This last set of questions explores whether the youth has plans for gender transition, hormone therapy, surgery, children, etc.

Research and the Evidence Base

Systemic therapy began as a research project: the Bateson team began by studying communication in families with members diagnosed with schizophrenia. The tradition of observational research has been integrated into required standard training in systemic and strategic models in the form of observation teams. There has not been a lot systematic research on outcomes of specific systemic models—such as strategic, Milan, or MRI—however, there is consistent and growing research on the effectiveness of evidence-based systemic approaches for specific conditions, such as adolescent substance abuse, adolescent conduct issues, depression related to relationship distress, severe mental illness, and couples distress (Sprenkle, 2012). These evidence-based treatments use key theoretical concepts and techniques from systemic family therapies and apply them to a specific population.

Systemic therapies are quickly emerging as a leading force in the realm of evidence-based treatments. Numerous empirically supported treatments incorporate key elements of systemic and strategic therapies, including:

- **Multisystemic Family Therapy** (Henggeler et al., 1998; see "Clinical Spotlight" in this chapter)
- **Brief Strategic Family Therapy** (structural ecosystemic therapy, structural ecodevelopmental preventive interventions; see Clinical Spotlight in this chapter; Szapocznik & Williams, 2000)
- **Ecosystemic Structural Therapy** (see Chapter 5; Lindblad-Goldberg, Dore, & Stern, 1998)
- **Multidimensional Family Therapy** (Liddle, Dakof, & Diamond, 1991)
- **Functional Family Therapy** (see Chapter 5)
- **Emotionally Focused Couples Therapy** (see Chapter 6)

Although each of these approaches is unique, they all incorporate identifying the problem interaction sequence and in some way interrupting or altering it and using one or more systemic or strategic techniques to address the needs of a specific population.

Clinical Spotlight: Multisystemic Therapy

Multisystemic therapy (MST) was developed in the 1970s to treat serious juvenile offenders (Multisystemic Therapy Services, 1998). A family-based treatment model, MST draws from strategic, structural, socioecological, and cognitive–behavioral therapy models. In addition, MST also places significant emphasis on the adolescent's and family's broader social network, removing offenders from problematic social networks, improving school and/or vocational performance, and developing a strong support network for the child and the family (Henggeler, 1998; Henggeler & Borduin, 1990; Multisystemic Therapy Services, 1998).

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Goals

The overarching goals of MST include the following:

- Decrease antisocial behavior and other clinical problems
- Improve functioning in family relations
- Improve functioning in school and/or work contexts
- Minimize out-of-home placements, including incarceration, residential treatment, and hospitalization

Case Conceptualization

When conceptualizing treatment, MST therapists consider risks and protective factors in the following domains: individual, family, peer, school, and neighborhood and community (Multisystemic Therapy Services, 1998).

	Risks	Protective Factors
Individual	Positive attitude toward antisocial behavior, psychological symptoms, hostility, low intellectual functioning and verbal skills	Intelligence, eldest child, easygoing personality, prosocial values, problem-solving skills
Family	Lack of parental supervision, ineffective or inconsistent discipline, lack of emotional expression, conflict, parental difficulties	Connection to parents and family, supportive family, strong parental relationship
Peer	Association with socially deviant peers, poor relational skills, few prosocial friends	Connections with prosocial friends
School	Poor performance, little interest, little support	Committed to education, goals, acceptable performance
Neighborhood and community	High family mobility, criminal subculture, disorganized	Involvement in religious or social organizations, strong support network

Principles of Intervention

1. **Finding the fit:** The therapist assesses how the adolescent's problems fit systemically within the broader family, peer, school, and community culture.
2. **Focus on positives and strengths:** Therapeutic interactions emphasize strengths and potential strengths, in both the individual adolescent and the family.
3. **Increasing responsibility:** Interventions aim to increase responsible behavior with all family members, promoting parental involvement and helping teens accept responsibility for their choices.
4. **Focus on the present, on action, and on clarity:** Interventions are action-oriented and present-focused, and they target specific, easily defined problems that are easily tracked and measured, such as achieving a specific grade point average or adhering to a curfew.
5. **Targeting sequences:** Consistent with its systemic foundation, sequences of behaviors are the target of change; these sequences can be between family members or with peers and the larger social systems.

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6. **Developmentally appropriate:** Interventions are developmentally appropriate for youth, promoting step-by-step advancement of the competencies and skills needed for success as an adult.
7. **Continuous effort:** Interventions, by design, require daily or weekly effort from the family.
8. **Evaluation and accountability:** Rather than blame the family if an intervention does not work, MST continually assesses the effectiveness of interventions and adjusts as necessary to ensure success.
9. **Generalization:** Treatment is designed to help the adolescent and family generalize their skills and abilities to solve problems in other life areas.

Clinical Spotlight: Brief Strategic Family Therapy

Drawing on structural and strategic therapies, Jose Szapocznik and his colleagues at the Center for Family Studies developed brief strategic family therapy (BSFT) to address drug abuse problems with Cuban youth in Miami (Szapocznik & Williams, 2000; Szapocznik, Hervis, & Schwartz, 2003). Expanded and adopted to treat African Americans and other Hispanic populations, this therapy is recognized as an evidence-based approach; a complete manual is available through the National Institute for Drug Abuse website (Santisteban et al., 1997; Szapocznik et al., 2003). BSFT is based on three central concepts: *systems, structure* (patterns of interaction), and *strategy*.

Goals

Brief strategic family therapy has two goals:

- Reduce or eliminate child drug use
- Change family interactions that are supporting the problem behaviors (youth drug use)

Case Conceptualization

In comparison with other evidence-based approaches, BSFT focuses primarily *within* family dynamics, using structural and strategic family therapy concepts (Santisteban, Suarez-Morales, Robbins, & Szapocznik, 2006; Szapocznik et al., 2003):

- **Structure and organization:** The therapist uses traditional structural concepts, such as subsystems, hierarchy, leadership, and coalitions, to assess the structure, organization, and flow of information in the family.
- **Resonance:** Using the structural therapy concepts of boundaries, the therapist assesses emotional resonance within the broader context of cultural norms: enmeshed (high resonance) and disengaged (low resonance).
- **Developmental stage:** The therapist uses the family's ability to adapt its structure to support members in their current life stage of development (e.g., increasing autonomy as children grow).
- **Life context:** The therapist assesses the effects of the family's broader social life, such as extended family, community, school, peers, and courts.
- **Identified patienthood:** The more the family believes the identified patient is to blame for all its problems, the more difficult it is to treat the family.
- **Conflict resolution:** The therapist assesses the family's style of conflict resolution:
  - Denial: Conflict is not allowed to emerge: "We have no problems."
  - Avoidance: When conflict arises, it is quickly stopped or covered up, such as by procrastinating, minimizing, or postponing difficult conversations.
  - Diffusion: When the problem is brought up, the subject is switched to another problem topic, often as a personal attack against the person who raised the issue.

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- Conflict emergence without resolution: Conflict occurs but no resolution is reached.
- Conflict emergence with resolution: The family is able to resolve the conflict.

Principles of Intervention

Interventions are deliberately chosen to target the aspects of family interactions that are most likely to achieve the desired outcome.

- **Joining:** The therapist uses structural family therapy, joining, to connect with the family system.
- **Enactments:** Structural enactments are used to assess family functioning and restructure family interactions.
- **Working in the present:** Interventions target current interactions with minimal focus on the past.
- **Reframing negativity:** Therapists reframe negative interpretations to promote caring and concern within the family.
- **Reversals:** Therapists may coach one or more family members to do or say the *opposite* of what is typically done or said.
- **Working with boundaries and alliances:** Standard structural techniques are used to either loosen or strengthen boundaries to better meet developmental needs.
- **Detriangulation:** The therapist may remove a third, less powerful person from a conflict between two others.
- **Opening closed systems:** Systems in which open conflict is not allowed must be "opened" to allow effective expression and resolution of differences.

QUESTIONS FOR PERSONAL REFLECTION AND CLASS DISCUSSION

1. Identify a personal characteristic of yours that has a strong systemic component (i.e., you are this way more in one relationship than another or has been exaggerated over the years due complementarity with a partner).
   - Does this characteristic feel like it is an inherent characteristic of "you" or does it feel "situational"?
   - Can you identify a characteristic of another person that seems "inherently in the individual" but may have more of a systemic basis to it?
   - Would you agree that to some extent all behavior is shaped by broader systemic and social dynamics? Why or why not?
2. What would "joining the system" look like in your family of origin?
3. Are you ready to "trust the system" to reorganize itself in a way that is best for itself? Why or why not?
4. Where are you currently in the family life cycle? How are approaching the tasks of balancing independence and interdependence?
5. Trace a problem interaction cycle in your life from "normal" through the rise in tension and symptom and back to "normal" again.
6. How do cultural communities function as a system in a person's life?
7. How do culture and gender play out in your family system?
8. How might the experience of being marginalized due to same-sex orientation affect a person's boundaries with:
   - A partner?
   - A supportive family of origin?
   - A nonsupportive family of origin?
   - Supportive friends?

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